The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Division of Health Professions Licensure

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APPLICATION FOR LICENSURE AS A WHOLESALER / DISTRIBUTOR / BROKER

The purpose of 247 CMR 7.00 is to implement the Federal Prescription Drug Marketing Act of 1987 ("PDMA"),U.S. Public Law 100-293, codified at 21 U.S.C. δδ 321 et seq. The PDMA requires that all entities engaged in the interstate and/or intrastate wholesale distribution of prescription drugs be licensed in each state where they are engaged in such activity.

247 CMR 7.00 applies to every wholesale distributor located in the Commonwealth of Massachusetts who engages in the sale, distribution, or delivery at wholesale of prescription drugs.

$600.00 licensure / application fee. Make check or money order for **$600.00** payable to the Commonwealth of Massachusetts. ***This fee is non-refundable***.

1. Legal Name of Business._____
2. Full Business Address (Street Address, City, State & Zip)._____
   _____
3. County_____
4. Area Code & Telephone Number._____ FEIN #:_____
5. Address, Telephone Number, Social Security Number, and Name of Contact Person (Designated Representative) for the facility.
   _____
   _____
6. All trade or business names ("DBA" names) used by same Corporation or by Licensee.
   _____
   _____

7. Type of ownership or operation (i.e., sole proprietorship, partnership, corporate distribution center for multi-unit (chain) pharmacy corporation._____

_____

If corporation, please submit articles of corporation.

8. Number of subsidiaries, related organizations, entities, or other facilities operating under the registration of the above listed business._____

9. Name(s) and Social Security Number(s) of the owner(s) and/or operator(s) of the licensee. Please indicate type of ownership - Partnerships: the name of each partner and name and address of partnership; Corporations: the name and title of each corporate officer and director, the corporate names, name and address of the parent company, if any, and the State of incorporation; Sole Proprietorships: the name of the sole proprietor and the name and address of the business entity.

_____

_____

_____

_____

10. Type of Operation: (Circle all that apply)

Full Service Wholesaler Manufacturer Repackager Buying Group/Import/Export

Distribution Center for Multiunit Distribution Center for Pharmacy Corporation

Other (specify)_____

11. Sell Drugs to: (Circle all that apply)

Intra-Company Sales Only Community Pharmacies Hospital Pharmacies Wholesalers

Physicians or Other Practitioners Licensed to Prescribe Veterinarians

Other(specify)_____

12. Type of Drugs Distributed: (Circle all that apply)

Controlled Substances (Schedules II-V) Non-Federally Controlled Prescription Drugs (Schedule VI)

Over-the-Counter Drugs

Other (specify)_____

Which schedules_____

13. If controlled substances are to be distributed, a controlled substance license is required from the Drug Enforcement Agency (Schedules II-V), Massachusetts Board of Registration in Pharmacy and the Department of Public Health – Drug Control Program.

14. Please submit with this application a detailed certified blueprint(s) of each facility drawn to scale.

15. Have any of the applicant(s) and/or managers-in-charge had: 1) any convictions related to the distribution of drugs (including samples); 2) any felony convictions; 3) any suspension(s) or revocation(s) or other sanctions(s) by federal, state or local governmental agency of any license or registration currently or previously held by the applicant or licensee for the manufacture or distribution of any drugs, including controlled substances? Have any applications for licensure been denied by any federal or state agency? List and explain. Attach additional sheets if necessary.

_____
_____
_____
_____

16. The applicant / licensee must notify the Board in writing of any changes in ownership or management within thirty (30) days of such change(s).

17. List state(s) in which application for licensure is being made.

_____
_____
_____

18. List state(s) in which licensure has been granted.

_____

Provide details for each facility, using the form below. Photocopy this form and attach sheet(s) if necessary.

Name and address of each facility: (Street Address, City, State, Zip & County)	Area code and Telephone number of each facility	Full name, emergency telephone and social security
1. _____ _____ _____ _____	( ) -	Full Name: Telephone: SSN:
2._____ _____ _____ _____	( ) -	Full Name: Telephone: SSN:
3._____ _____ _____ _____	( ) -	Full Name: Telephone: SSN:
4._____ _____ _____ _____	( ) -	Full Name: Telephone: SSN:

Licensure Information for Each Facility

Photocopy this form and attach additional sheets if necessary. If the information is unavailable, please indicate N/A.

State(s) Where Licensed List all:	License Number and Expiration Date: Number:	Date:	State Controlled Substances License #	DEA Registration Number:	FDA Number: (manufacturers only)

NOTE: Attach a copy of the most recent Board of Pharmacy inspection for each licensed facility For each state where licensed.

Affidavit (must be completed and notarized)

Pursuant to M.G.L.c.62C, s. 49, I certify under the penalties of perjury that I, to the best of my knowledge and belief, have filed all state tax returns and paid all state taxes required under law.

The applicant certifies that each person employed in any prescription drug wholesale distribution activity has the education, training, and experience, or any combination thereof, sufficient for that person to perform the assigned functions in such a manner as to provide assurance that the drug product quality, safety, and security will at all times be maintained as required by law.

I hereby state that I am the person authorized to sign this application for all licensure; that all statements are true and correct in all respects and are made under the penalties of perjury.

_____ _____ _____

Signature of Owner or Corporate Officer Title Date

_____

Social Security Number of Owner or Corporate Officer

Sworn and subscribed before me this _____day of _____.

My commission expires_____. _____

Notary Public

To be completed by the Board: Check $_____ Date_____ Number_____